2025

Comparative Guide

bestMed

personally yours

Contents

Why choose Bestmed?

Bestmed is *Personally Yours*

- **Excellent preventative care benefits** on all options to ensure the early detection of serious illness or medical conditions.
- Children qualify for **child dependant rates up to the age of 24 years.**
- Families pay for up to three child beneficiaries and the **rest are covered at no cost (All options except Rhythm1).**
- **Extensive maternity benefits,** including a maternity care programme.
- **Eight Managed Healthcare programmes,** including Back and neck preventative programme, Oncology care, HIV/AIDS care, Dialysis care, Alcohol and Substance Abuse care, Wound care, Stoma care and Maternity care.
- Bestmed is the **largest self-administered scheme** which means that administration costs are less than our competitors.
- Bestmed is the **fourth largest open medical scheme** in the country.
- Ranked at the **forefront of customer experience** in the medical schemes industry in the **2020, 2021 and 2022 South African Customer Satisfaction Index (SA-csi),** and rated **first** in the Medical Aid Companies category of the **Ask Afrika Orange Index** in 2020 and 2022. Bestmed was also honoured as the **News24 Medical Scheme of the Year** in the **News24 Business Awards 2024**.
- **More than 19 000 network provider** agreements.
- **Country-wide geographical healthcare network coverage.**

Free wellness programme: Tempo

- Live life at your Tempo with free health and wellness benefits for all beneficiaries, regardless of your benefit option.
- The Tempo Lifestyle Screening, available online for your convenience, will help you assess your overall health and wellness status.
- Fully funded in-person and/or virtual consultations with Bestmed Tempo partner biokineticists and dietitians.
- An established network of healthcare professionals supporting your physical, nutritional and mental wellbeing.

Be 'appy' and download the Bestmed App

The **Bestmed App** is just one more way that Bestmed is Personally Yours. It's user-friendly and has been designed to put all your essential medical aid information at your fingertips.

The app provides the following benefits:

- Access to a digital version of your membership card
- Find a service provider
- Submit a claim
- Check your available benefits
- Email your membership card to service providers
- Check your Tempo Lifestyle Screening results
- Update contact details for dependants 18 years and older
- Submit your chronic application/prescription

Download the Bestmed App from your preferred platform:

Google Play Store
Android devices

App Store
iOS devices

AppGallery
Huawei devices

Tempo

All you need to know about Tempo

WHAT IS TEMPO?

Tempo is our health and wellness programme that assists members in leading a healthier lifestyle and living their best lives.

WHY SHOULD I ACTIVATE TEMPO?

As a member, you and your family already have access to the Tempo benefits at no additional costs. By simply completing the Tempo Lifestyle Screening, you activate Tempo benefits and you will automatically have access to over a thousand healthcare professionals who are trained and motivated to help you improve your lifestyle and become the best version of yourself.

HOW DO I ACTIVATE THE PROGRAMME?

For your convenience the Tempo Lifestyle Screening is available for completion via the Tempo portal on the Bestmed App or website. Your data will reflect on the Tempo partner pharmacies' (Clicks, Dis-Chem, Van Heerden Pharmacy, Arrie Nel, and The Local Choice) systems for the registered nurse to also complete the biometric screening portion of the screening. The completed screening will give you an important overview of your health status, and guide you in terms of which areas require focus to improve your health.

Should you choose to make use of the Tempo physical wellbeing and/or nutrition benefits, the results will also be shared with our Tempo partner biokineticists and dietitians automatically.

WHAT ARE THE BENEFITS OF THE TEMPO WELLNESS PROGRAMME?

The Tempo wellness programme is focused on supporting you on your path to improving your health and realising the rewards that come with it. To ensure you achieve this, you will have access to the following benefits:

Tempo Lifestyle Screening for adults (beneficiaries 16 years and older) which includes:

- The Tempo lifestyle questionnaire
- Blood pressure check
- Cholesterol check
- Glucose check
- Height and weight measurement

Tempo physical wellbeing and nutrition benefits (beneficiaries 16 and older):

Physical wellbeing:

- 1 x **(face-to-face)** physical health assessment at a Tempo partner biokineticist
- 1 x follow-up **(virtual or face-to-face)** consult to obtain your personalised exercise plan from the Tempo partner biokineticist

Nutrition:

- 1 x **(face-to-face)** nutrition assessment at a Tempo partner dietitian
- 1 x follow-up **(virtual or face-to-face)** consult to obtain your personlised healthy-eating plan from the Tempo partner dietitian

In addition to the Tempo physical wellbeing and nutrition benefits, you will also have access to **Tempo Wellness Webinars** hosted monthly. The webinars are themed around mental health and various other wellness-related topics.

DO THE FREE BENEFITS DIFFER FOR MEMBERS ON DIFFERENT HEALTHCARE OPTIONS?

No. The Bestmed Tempo benefits are exactly the same on all the options.

We hope you found the answer you were looking for. If not, please email us for more information: **tempo@bestmed.co.za**

*All beneficiaries need to register their details on the Tempo portal to use the online features, and cannot register with the principal member's details.

bestMed tempo wellness programme

Beat

The Beat range offers flexible hospital benefits with savings on some options to pay for out-of-hospital expenses. Beat1, 2 and 3 also offer you the choice to lower your monthly contribution in the form of network options.

Method of Scheme benefit payment

BEAT1	BEAT2	BEAT3	BEAT3 PLUS	BEAT4
▪ In-hospital benefits are paid from Scheme risk. ▪ Some preventative care benefits are available from Scheme risk. ▪ Out-of-hospital benefits are paid from your own pocket.	▪ In-hospital benefits are paid from Scheme risk. ▪ Some preventative care benefits are available from Scheme risk. ▪ Out-of-hospital benefits are paid from your medical savings account (savings).	▪ In-hospital benefits are paid from Scheme risk. ▪ Some preventative care benefits are available from Scheme risk. ▪ Some out-of-hospital benefits are paid from Scheme risk and some from your medical savings account (savings).		▪ In-hospital benefits are paid from Scheme risk. ▪ Some preventative care benefits are available from Scheme risk. ▪ Some out-of-hospital benefits are paid from your medical savings account (savings) first, once depleted, from your day-to-day benefit.

- Benefits relating to conditions that meet the criteria for PMBs will be covered in full when using DSPs, this will not affect your savings (annual or vested) for applicable options.

BEAT NETWORK PLAN OPTION

- Bestmed offers members a choice of network hospitals for in-hospital benefits.
- If a member voluntarily chooses not to make use of a hospital within the Beat network, a maximum co-payment of R14 364 will apply.

In-hospital benefits

The non-network (standard) Beat options provide you with access to any hospital of your choice. The network options provide you with a list of designated hospitals for you to use and also allows you to save.

Benefits relating to conditions that meet the criteria for PMBs will be covered in full when using DSPs, and this will not affect your savings.

Note: All the below benefits are subject to pre-authorisation and clinical protocols.

All members must obtain pre-authorisation for planned procedures at least 14 (fourteen) days before the event. However, in the case of an emergency, you, your representative or the hospital must notify Bestmed of your hospitalisation as soon as possible or on the first working day after admission to hospital.

	BEAT1	BEAT2	BEAT3	BEAT3 PLUS	BEAT4
Accommodation (hospital stay) and theatre fees	100% Scheme tariff.				
Take-home medicine	100% of Scheme tariff, limited to a maximum of 7 days treatment provided that: ▪ the medicine is claimed as part of the hospital account; or ▪ R150 if medicine is claimed from a retail pharmacy on the date of discharge; and ▪ subject to MRP. No benefit if not claimed on the date of discharge.				
Biological medicine during hospitalisation	Limited to R11 610 per family per annum. Subject to pre-authorisation and funding guidelines.	Limited to R17 414 per family per annum. Subject to pre-authorisation and funding guidelines.	Limited to R23 218 per family per annum. Subject to pre-authorisation and funding guidelines.		Limited to R29 022 per family per annum. Subject to pre-authorisation and funding guidelines.
Treatment in mental health facilities	100% Scheme tariff. Limited to 21 days per beneficiary per financial year in hospital, including inpatient electro-convulsive therapy and inpatient psychotherapy, OR 15 contact sessions for out-patient psychotherapy per beneficiary per financial year. Subject to pre-authorisation and DSPs.				
Treatment of chemical and substance abuse	Benefits shall be limited to the treatment of PMB conditions and subject to the following: ▪ Pre-authorisation ▪ DSPs ▪ 21 days' stay for in-hospital management per beneficiary per annum.				
Consultations and procedures	100% Scheme tariff.				
Surgical procedures and anaesthetics	100% Scheme tariff.				
Organ transplants	100% Scheme tariff (PMBs only).				
Stem cell transplants	100% Scheme tariff (PMBs only).	100% Scheme tariff (PMBs only).	100% Scheme tariff (PMBs only).	100% Scheme tariff (PMBs only).	100% Scheme tariff (PMBs only).
Major maxillofacial surgery, strictly related to certain conditions	No benefit. (PMBs only).		100% Scheme tariff. Limited to R15 658 per family per annum.		100% Scheme tariff. Limited to R15 945 per family per annum.

	BEAT1	BEAT2	BEAT3	BEAT3 PLUS	BEAT4
Dental and oral surgery (in or out of hospital)	PMBs only at DSP day hospitals.	PMBs only at DSP day hospitals. **Beneficiaries 7 years and younger** Limited to R6 350 per family per annum. **Beneficiaries over 7 years** Dental surgical procedures paid from savings for procedures performed in the doctor's rooms only.	Limited to R9 768 per family per annum.	Limited to R9 768 per family per annum.	Limited to R12 210 per family per annum.
Overall annual prosthesis limit (subject to preferred providers and DSPs, otherwise limits and co-payments apply)	100% Scheme tariff. Limited to R95 377 per family per annum.		100% Scheme tariff. Limited to R96 384 per family per annum.		100% Scheme tariff. Limited to R117 652 per family per annum.
Prosthesis – Internal **Note: Sub-limits subject to availability of overall prosthesis limit. DSPs apply.** ***Functional: Items used to replace or augment an impaired bodily function.**	Sub-limits per beneficiary per annum: ▪ *Functional R34 047. ▪ Vascular R54 915. ▪ Pacemaker (single and dual chamber) R51 998. ▪ Spinal including artificial disc R38 068. ▪ Drug-eluting stents – subject to Vascular prosthesis limit. ▪ Mesh R13 360. ▪ Gynaecology/urology R10 917. ▪ Lens implants R8 330 a lens per eye.		Sub-limits per beneficiary per annum: ▪ *Functional R35 146. ▪ Vascular R65 898. ▪ Pacemaker (single and dual chamber) R51 998. ▪ Spinal including artificial disc R38 208. ▪ Drug-eluting stents – subject to Vascular prosthesis limit. ▪ Mesh R13 429. ▪ Gynaecology/urology R11 091. ▪ Lens implants R8 330 a lens per eye.		Sub-limits per beneficiary per annum: ▪ *Functional R37 342. ▪ Vascular R71 390. ▪ Pacemaker (single and dual chamber) R68 086. ▪ Spinal including artificial disc R40 652. ▪ Drug-eluting stents R22 839. ▪ Mesh R15 083. ▪ Gynaecology/urology R11 061. ▪ Lens implants R8 618 a lens per eye.
Exclusions (Prosthesis sub-limits form part of overall Internal prosthesis subject to preferred provider, otherwise limits and co-payments apply).	Joint replacement surgery (except for PMBs). PMBs subject to prosthesis limits: ▪ Hip replacement and other major joints R40 075. ▪ Knee replacement R49 413. ▪ Other minor joints R15 371.		Joint replacement surgery (except for PMBs). PMBs subject to prosthesis limits: ▪ Hip replacement and other major joints R40 364. ▪ Knee replacement R49 944. ▪ Other minor joints R15 371.		Joint replacement surgery (except for PMBs).PMBs subject to prosthesis limits: ▪ Hip replacement and other major joints R41 800. ▪ Knee replacement R55 532. ▪ Other minor joints R17 063.
Prosthesis – External	No benefit (PMBs only).				Limited to R28 297 per family. Includes artificial limbs, limited to one (1) limb every 60 months. Repair work to artificial limbs will be funded from the out-of-hospital Medical aids, apparatus and appliances benefit.
Breast surgery for cancer	Treatment of the **unaffected (non-cancerous) breast** will be limited to PMB provisions and is subject to pre-authorisation and funding guidelines.				
Orthopaedic and medical appliances **Note: Appliances directly relating to the hospital admission and/or procedure**	100% Scheme tariff. Limited to R15 000 per family per annum. Subject to PMB level of care.				
Pathology	100% Scheme tariff.				
Basic radiology	100% Scheme tariff.				

	BEAT1	BEAT2	BEAT3	BEAT3 PLUS	BEAT4
Specialised diagnostic imaging - in- and/or out-of-hospital (including MRI scans, CT scans and nuclear/isotope studies). PET scans only included as indicated per benefit option.	Limited to a combined in- and out-of-hospital benefit of R20 000 per family per annum. Co-payment of R2 600 per scan, not applicable to PMBs. PET scans - PMB only. Subject to pre-authorisation.	Limited to a combined in- and out-of-hospital benefit of R22 000 per family per annum. Co-payment of R2 100 per scan, not applicable to PMBs. PET scans - PMB only. Subject to pre-authorisation.	Limited to a combined in- and out-of-hospital benefit of R32 000 per family per annum. Co-payment of R2 000 per scan, not applicable to PMBs. PET scans - PMB only. Subject to pre-authorisation.	Limited to a combined in- and out-of-hospital benefit of R35 000 per family per annum. Co-payment of R2 000 per scan, not applicable to PMBs. PET scans - PMB only. Subject to pre-authorisation.	Limited to a combined in- and out-of-hospital benefit of R40 000 per family per annum. Co-payment of R2 000 per scan, not applicable to PMBs. PET scans are limited to one (1) scan per beneficiary per annum, not subject to the abovementioned limit or co-payment. Subject to pre-authorisation.
Oncology	Subject to pre-authorisation, protocols and DSP.				
Peritoneal dialysis and haemodialysis	100% Scheme tariff. Subject to pre-authorisation and DSPs.				
Confinements (birthing)	100% Scheme tariff.				
HIV/AIDS	100% Scheme tariff. Subject to pre-authorisation and DSPs.				
Refractive surgery and other procedures done to improve or stabalise vision (except cataracts)	PMBs only.		100% Scheme tariff. Subject to pre-authorisation and protocols. Limited to R10 055 per eye.		100% Scheme tariff. Subject to pre-authorisation and protocols. Limited to R 11 349 per eye.
Midwife-assisted births	100% Scheme tariff.				
Supplementary services	100% Scheme tariff.				
Alternative to hospitalisation (i.e. procedures done in the doctor's rooms)	100% Scheme tariff.				
Advanced illness benefit	100% Scheme tariff, limited to R69 654 per beneficiary per annum. Subject to available benefit, pre-authorisation and treatment plan.				100% Scheme tariff, limited to R104 482 per beneficiary per annum. Subject to available benefit, pre-authorisation and treatment plan.
Day procedures	Day procedures performed in a day hospital by a DSP provider will be funded at 100% network or Scheme, subject to: pre-authorisation; protocols and funding guidelines; and DSPs. A co-payment of R2 746 will be incurred per event if a day procedure is done in an acute hospital that is not a day hospital. If a DSP is used and the DSP does not work in a day hospital, the procedure shall be paid in full if it is done in an acute hospital, if it is arranged with the Scheme before the time.				
International medical travel cover	▪ Holiday travel: Limited to 90 days and R5 000 000 per family, i.e. members and dependants. Limited to R1 000 000 per family for travel to the USA. ▪ Business travel: Limited to 60 days and R5 000 000 per family, i.e. members and dependants. Limited to R1 000 000 per family for travel to the USA.				
Co-payments	**Non-network hospital co-payment:** Co-payment for voluntary use of non-network hospital R14 364. Applicable to network options. **Procedure-specific co-payments:** The co-payment shall not apply to PMB conditions: ▪ Arthroscopic procedures R3 660. ▪ Back and neck surgery R3 660. ▪ Functional nasal and sinus procedures R2 000. ▪ Laparoscopic procedures R3 660. ▪ Colonoscopies R2 000. ▪ Cystoscopies R2 000. ▪ Gastroscopies R2 000. ▪ Hysteroscopies R2 000. ▪ Sigmoidoscopies R2 000. ▪ Extraction of wisdom teeth R2 500. A R2 746 co-payment, as described in the Day procedures benefit, will be incurred per event if a day procedure is done in an acute hospital that is not a day hospital.				

Out-of-hospital benefits

Note: Benefits below may be subject to pre-authorisation, clinical protocols, preferred providers, designated service providers (DSPs), formularies, funding guidelines and the Mediscor Reference Price (MRP).

Members are required to obtain pre-authorisation for all planned treatments and/or procedures, PMB services and chronic medication.

	BEAT1	BEAT2	BEAT3	BEAT3 PLUS	BEAT4
Overall day-to-day limit	Not applicable.				M = R15 513, M1+ = R31 025.
General Practitioner (GP), nurse and specialist consultations	No benefit.	Savings account.	Savings account.	Savings account.	Savings first. Limited to M = R3 951, M1+ = R7 037. (Subject to overall day-to-day limit)
Basic and specialised dentistry	No benefit.	**Basic:** Preventative benefit or savings account. **Specialised:** Savings account. **Orthodontic:** Subject to pre authorisation.			Savings first. Limited to M = R6 835, M1+ = R13 728. (Subject to overall day-to-day limit) Orthodontics are subject to pre-authorisation.
Medical aids, apparatus and appliances including wheelchairs	No benefit.	Savings account.	Savings account.	Savings account.	Savings first. Limited to R13 934 per family. Includes repairs to artificial limbs. 100% Scheme tariff. (Subject to overall day-to-day limit).
Hearing aids (Subject to pre-authorisation)	No benefit.	Savings account.	Savings account.	Savings account.	Limited to R12 770 per family every 24 months. 100% Scheme tariff. Subject to quotation, motivation and audiogram.
Supplementary services	No benefit.	Savings account.	Savings account.	Limited to R2 092 per family per annum. Thereafter, savings account.	Savings first. Limited to M = R6 033, M1+ = R12 253. (Subject to overall day-to-day limit)
Wound care benefit (incl. dressings, negative pressure wound therapy -NPWT- treatment and related nursing services -out-of-hospital)	100% Scheme tariff. Limited to R4 267 per family.				Savings first. 100% Scheme tariff. Limited to R6 033 per family. (Subject to overall day-to-day limit)
Basic radiology and pathology	No benefit.	Savings account.			Savings first. Limited to M = R3 950, M1+ = R8 044. (Subject to overall day-to-day limit)
Specialised diagnostic imaging - in- and/or out-of-hospital (including MRI scans, CT scans and nuclear/isotope studies). PET scans only included as indicated per benefit option.	Limited to a combined in- and out-of-hospital benefit of R20 000 per family per annum. Co-payment of R 2 600 per scan, not applicable to PMBs. PET scans - PMB only. Subject to pre-authorisation.	100% Scheme tariff. Limited to a combined in- and out-of-hospital benefit of R22 000 per family per annum. Co-payment of R 2 100 per scan, not applicable to PMBs. PET scans - PMB only. Subject to pre-authorisation.	100% Scheme tariff. Limited to a combined in- and out-of-hospital benefit of R32 000 per family per annum. Co-payment of R 2 000 per scan, not applicable to PMBs. PET scans - PMB only. Subject to pre-authorisation.	100% Scheme tariff. Limited to a combined in- and out-of-hospital benefit of R35 000 per family per annum. Co-payment of R 2 000 per scan, not applicable to PMBs. PET scans - PMB only. Subject to pre-authorisation.	100% Scheme tariff. Limited to a combined in- and out-of-hospital benefit of R40 000 per family per annum. Co-payment of R 2 000 per scan, not applicable to PMBs. PET scans are limited to one (1) scan per beneficiary per annum, not subject to the abovementioned limit or co-payment. Subject to pre-authorisation.
Rehabilitation services after trauma	PMBs only. Subject to pre-authorisation and DSPs.				100% Scheme tariff.
Back and neck preventative programme	Benefits payable at 100% of contracted fee. Subject to pre-authorisation, protocols and DSPs.				
HIV/AIDS	100% Scheme tariff. Subject to pre-authorisation and DSPs.				
Oncology	Oncology programme at 100% of Scheme tariff. Subject to pre-authorisation, protocols and DSP.				

	BEAT1	BEAT2	BEAT3	BEAT3 PLUS	BEAT4
Peritoneal dialysis and haemodialysis	100% Scheme tariff. Subject to pre-authorisation and DSPs.				
Optometry benefit	No benefit.	Savings account.	Savings account.	Benefits available every 24 months from date of service. **Network Provider (PPN)** Consultation - One (1) per beneficiary. Frame = R945 covered AND 100% of cost of standard lenses (single vision OR bifocal OR multifocal) OR Contact lenses = R1 710 OR **Non-network Provider** Consultation - R400 fee at non-network provider Frame = R709 AND Single vision lenses = R215 OR Bifocal lenses = R460 OR Multifocal lenses = R1 040 (consisting of R810 per base lens plus R230 per branded lens add-on) In lieu of glasses members can opt for contact lenses, limited to R1 710	Benefits available every 24 months from date of service. **Network Provider (PPN)** Consultation - One (1) per beneficiary. Frame = R1 210 covered AND 100% of cost of standard lenses (single vision OR bifocal OR multifocal) OR Contact lenses = R2 025 OR **Non-network Provider** Consultation - R400 fee at non-network provider Frame = R908 AND Single vision lenses = R215 OR Bifocal lenses = R460 OR Multifocal lenses = R1 040 (consisting of R810 per base lens plus R230 per branded lens add-on) In lieu of glasses members can opt for contact lenses, limited to R2 025

Medicine benefits

Note: Benefits mentioned below may be subject to pre-authorisation, clinical protocols, preferred providers, designated service providers (DSPs), formularies, funding guidelines, the Mediscor Reference Price (MRP), and the exclusions referred to in Annexure C of the registered Rules. Approved CDL, PMB and non-CDL chronic medicine costs will be paid from the non-CDL chronic medicine limit first. Thereafter, approved CDL and PMB chronic medicine costs will continue to be paid (unlimited) from Scheme risk.

Members will not incur co-payments for approved PMB medications that are on the formulary for which there is no generic alternative.

Note: Refer to the Chronic Conditions List at the back of the Comparative Guide.

	BEAT1	BEAT2	BEAT3	BEAT3 PLUS	BEAT4
CDL & PMB chronic medicine*	100% Scheme tariff. Co-payment of 30% for non-formulary medicine.				100% Scheme tariff. Co-payment of 20% for non-formulary medicine.
Non-CDL chronic medicine	No benefit.		5 conditions. 80% Scheme tariff. Limited to M = R4 166, M1+ = R8 475. Co-payment of 30% for non-formulary medicine.		9 conditions. 90% Scheme tariff. Limited to M = R9 150, M1+ = R18 301. Co-payment of 20% for non-formulary medicine.
Biologicals and other high-cost medicine	PMBs only as per funding protocol. Subject to pre-authorisation.				
Acute medicine	No benefit.	Savings account.			Savings first. Limited to M = R3 491, M1+ = R7 052. (Subject to overall day-to-day limit)
Over-the-counter (OTC) medicine **Includes sunscreen, vitamins and minerals with NAPPI codes on Scheme formulary**	No benefit.	Savings account.			**Member choice: R1 161 OTC limit per family OR Access to full savings for OTC purchases (after R1 161 limit) = self-payment gap accumulation. Subject to available savings.

*For Beat3, Beat3 Plus and Beat4, approved medicines for the following conditions are not subject to the non-CDL limit: organ transplant, chronic renal failure, multiple sclerosis, haemophilia. Medicine claims will be paid directly from Scheme risk.

**The default OTC choice is 1. R1 161 OTC limit. Members wishing to choose the self-payment gap accumulation option are welcome to contact Bestmed.

Preventative care benefits

Note: Benefits mentioned below may be subject to pre-authorisation, clinical protocols, preferred providers, designated service providers (DSPs), formularies, funding guidelines and the Mediscor Reference Price (MRP).

	BEAT1	BEAT2	BEAT3	BEAT3 PLUS	BEAT4
Preventative care benefits **Note: Refer to Scheme rules for funding criteria applicable to each preventative care benefit.**	▪ Flu vaccines. ▪ Pneumonia vaccines. ▪ Three baby growth and development assessments per year for children 0-2 years. ▪ Female contraceptives – R2 000 per beneficiary per year. ▪ Pap smear – ages 18 and above, every 24 months. ▪ HPV vaccinations. ▪ Mammogram – females ages 40 and above, every 24 months.	▪ Flu vaccines. ▪ Pneumonia vaccines. ▪ Travel vaccines. ▪ Paediatric immunisations. ▪ Three baby growth and development assessments per year for children 0-2 years. ▪ Female contraceptives R2 200 per beneficiary per year. ▪ Intrauterine device (IUD) insertion (consultation and procedure) by a GP or gynaecologist. Once every 5 years. ▪ Preventative dentistry. ▪ Pap smear – ages 18 and above, every 24 months. ▪ HPV vaccinations. ▪ Mammogram – females ages 40 and above, every 24 months. ▪ PSA Screening – males ages 50 years and above, every 24 months.	▪ Flu vaccines. ▪ Pneumonia vaccines. ▪ Travel vaccines. ▪ Paediatric immunisations. ▪ Three baby growth and development assessments per year for children 0-2 years. ▪ Female contraceptives R2 400 per beneficiary per year. ▪ Intrauterine device (IUD) insertion (consultation and procedure) by a GP or gynaecologist. Once every 5 years. ▪ Preventative dentistry. ▪ Pap smear – ages 18 and above, every 24 months. ▪ HPV vaccinations. ▪ Mammogram – females ages 40 and above, every 24 months. ▪ PSA Screening – males ages 50 years and above, every 24 months.		▪ Flu vaccines. ▪ Pneumonia vaccines. ▪ Travel vaccines. ▪ Paediatric immunisations. ▪ Three baby growth and development assessments per year for children 0-2 years. ▪ Female contraceptives – R2 678 per beneficiary per year. ▪ Intrauterine device (IUD) insertion (consultation and procedure) by a GP or gynaecologist. Once every 5 years. ▪ Preventative dentistry. ▪ Mammogram – females ages 40 and above, every 24 months. ▪ HPV vaccinations. ▪ PSA Screening – males ages 50 years and above, every 24 months. ▪ Pap smear (procedure and consultation) – ages 18 and above, every 24 months.

PREVENTATIVE DENTISTRY

General full-mouth examination by a general dentist (incl. gloves and use of sterile equipment)	No benefit	Once a year for members 12 years and above. Twice a year for members under 12 years.
Full-mouth intra-oral radiographs	No benefit	Once every 36 months for all ages.
Intra-oral radiograph	No benefit	Two (2) photos per year for all ages.
Scaling and/or polishing	No benefit	Twice per year (i.e. every 6 months from the date of service) for all ages.
Fluoride treatment	No benefit	Twice per year (i.e. every 6 months from the date of service) for all ages.
Fissure sealing	No benefit	Up to and including 21 years. Frequency must be in accordance with accepted protocol.
Space maintainers	No benefit	Once per space during the primary and mixed denture stage.

Disclaimer on exclusions: General and option-specific exclusions apply. Please refer to www.bestmed.co.za for more details.

Maternity benefits

Note: Benefits mentioned below may be subject to registration, preferred providers, designated service providers (DSPs), formularies, funding guidelines and the Mediscor Reference Price (MRP).

BEAT1	BEAT2	BEAT3	BEAT3 PLUS	BEAT4
100% Scheme tariff. Subject to the following benefits: **Consultations:** ▪ 6 antenatal consultations at a GP OR gynaecologist OR midwife. **Ultrasounds:** ▪ 1 x 2D ultrasound scan at 1st trimester (between 10 to 12 weeks) at a GP OR gynaecologist OR radiologist. ▪ 1 x 2D ultrasound scan at 2nd trimester (between 20 to 24 weeks) at a GP OR gynaecologist OR radiologist.		100% Scheme tariff. Subject to the following benefits: **Consultations:** ▪ 9 antenatal consultations at a GP OR gynaecologist OR midwife. ▪ 1 post-natal consultation at a GP OR gynaecologist OR midwife. **Ultrasounds:** ▪ 1 x 2D ultrasound scan at 1st trimester (between 10 to 12 weeks) at a GP OR gynaecologist OR radiologist. ▪ 1 x 2D ultrasound scan at 2nd trimester (between 20 to 24 weeks) at a GP OR gynaecologist OR radiologist. **Supplements:** ▪ Any item categorised as a maternity supplement can be claimed up to a maximum of R139 per claim, once a month, for a maximum of 9 months.		

Contributions

		BEAT1 N	BEAT1	BEAT2 N	BEAT2	BEAT3 N	BEAT 3	BEAT3 PLUS	BEAT4
Medical Savings Account		**N/A**		**16%**		**15%**		**25%**	**14%**
Principal Member	Risk	R2 111	R2 347	R2 168	R2 411	R3 212	R3 569	R3 636	R5 875
	Savings	R0	R0	R413	R459	R567	R630	R1 212	R956
	Total	**R2 111**	**R2 347**	**R2 581**	**R2 869**	**R3 779**	**R4 199**	**R4 848**	**R6 832**
Adult Dependant	Risk	R1 641	R1 822	R1 684	R1 872	R2 291	R2 546	R2 614	R4 852
	Savings	R0	R0	R321	R356	R405	R449	R872	R790
	Total	**R1 641**	**R1 822**	**R2 006**	**R2 228**	**R2 696**	**R2 995**	**R3 485**	**R5 642**
Child Dependant	Risk	R889	R987	R912	R1 015	R1 134	R1 259	R1 327	R1 452
	Savings	R0	R0	R174	R193	R200	R222	R442	R237
	Total	**R889**	**R987**	**R1 086**	**R1 208**	**R1 334**	**R1 482**	**R1 769**	**R1 689**
Maximum contribution child dependants*		3							
Recognition of a child dependant		Dependants under the age of 24 years are regarded as child dependants.							

* You only pay for a maximum of three children. Any additional children join as beneficiaries of the Scheme at no additional cost.

ABBREVIATIONS

CDL = Chronic Disease List; DBC = Documentation Based Care (back rehabilitation programme); DSP = Designated Service Provider; GP = General Practitioner or Doctor; HPV = Human Papilloma Virus; M = Member; M1+ = Member and family; MRP = Mediscor Reference Price; PMB = Prescribed Minimum Benefit; PPN = Preferred Provider Negotiators; PSA = Prostate Specific Antigen.

Pace

The Pace range offers comprehensive in-hospital and out-of-hospital benefits. These options all have additional day-to-day benefits to cover extensive out-of-hospital expenses. This range is ideal for those seeking comprehensive cover.

Method of Scheme benefit payment

PACE1	PACE2	PACE3	PACE4
▪ In-hospital benefits are paid from Scheme risk benefit. Some out-of-hospital benefits are paid from the annual savings first and once depleted will be paid from the day-to-day benefit. ▪ Once the day-to-day benefit is depleted, benefits can be paid from the available vested savings. Some preventative care benefits are available from Scheme risk benefit.			▪ In-hospital benefits, out-of-hospital benefits and preventative care benefits are paid from Scheme risk. ▪ Once out-of-hospital risk benefits are depleted, further claims will be paid from savings.

▪ Benefits relating to conditions that meet the criteria for PMBs will be covered in full when using DSPs, this will not affect your savings (annual or vested).

In-hospital benefits

Benefits relating to conditions that meet the criteria for PMBs will be covered in full when using DSPs, and this will not affect your savings.

Note: All the below benefits are subject to pre-authorisation and clinical protocols.

All members must obtain pre-authorisation for planned procedures at least 14 (fourteen) days before the event. However, in the case of an emergency, you, your representative or the hospital must notify Bestmed of your hospitalisation as soon as possible or on the first working day after admission to hospital.

	PACE1	PACE2	PACE3	PACE4
Accommodation (hospital stay) and theatre fees	100% Scheme tariff.			
Take-home medicine	100% of Scheme tariff, limited to a maximum of 7 days treatment provided that: ▪ the medicine is claimed as part of the hospital account; or ▪ R200 if medicine is claimed from a retail pharmacy on the date of discharge; and ▪ subject to MRP. No benefit if not claimed on the date of discharge.			
Biological medicine during hospitalisation	Limited to R34 828 per family per annum. Subject to pre-authorisation and funding guidelines.	Please refer to the Biological and other high-cost medicine benefit under Medicine on p.19 of this guide.		
Treatment in mental health facilities	100% Scheme tariff. Limited to 21 days per beneficiary per financial year in hospital, including inpatient electro-convulsive therapy and inpatient psychotherapy, OR 15 contact sessions for out-patient psychotherapy per beneficiary per financial year. Subject to pre-authorisation and DSPs.			
Treatment of chemical and substance abuse	Benefits shall be limited to the treatment of PMB conditions and subject to the following: ▪ Pre-authorisation ▪ DSPs ▪ 21 days' stay for in-hospital management per beneficiary per annum.			
Consultations and procedures	100% Scheme tariff.			
Surgical procedures and anaesthetics	100% Scheme tariff.			
Organ transplants	100% Scheme tariff. (PMBs only)			
Stem cell transplants	100% Scheme tariff (PMBs only).			
Major maxillofacial surgery, strictly related to certain conditions	100% Scheme tariff. Limited to R15 800 per family per annum.	100% Scheme tariff.		
Dental and oral surgery (in or out of hospital)	Limited to R9 768 per family per annum.	Limited to R16 232 per family per annum.	Limited to R20 397 per family per annum.	Limited to R24 419 per family per annum.
Overall annual prosthesis limit (subject to preferred provider, otherwise limits and co-payments apply)	100% Scheme tariff. Limited to R109 167 per family.	100% Scheme tariff. Limited to R140 193 per family.	100% Scheme tariff. Limited to R140 912 per family.	100% Scheme tariff. Limited to R162 601 per family.

	PACE1	PACE2	PACE3	PACE4
Prosthesis – Internal **Note: Sub-limits subject to availability of overall prosthesis limit.** ***Functional: Items used to replace or augment an impaired bodily function.**	Sub-limits per beneficiary per annum: ▪ *Functional R37 342. ▪ Vascular R71 390. ▪ Pacemaker (single and dual chamber) R67 943. ▪ Spinal including artificial disc R39 788. ▪ Drug-eluting stents – subject to Vascular prosthesis limit. ▪ Mesh R14 939. ▪ Gynaecology/urology R10 773. ▪ Lens implants R8 188 a lens per eye.	Sub-limits per beneficiary per annum: ▪ *Functional R39 539. ▪ Vascular R71 390. ▪ Pacemaker (single and dual chamber) R75 770. ▪ Spinal including artificial disc R70 284. ▪ Drug-eluting stents R22 983. ▪ Mesh R22 983. ▪ Gynaecology/urology R17 164. ▪ Lens implants R14 738 a lens per eye. ▪ Joint replacements: - Hip replacement and other major joints R63 129. - Knee replacement R73 257. - Other minor joints R27 219.	Sub-limits per beneficiary per annum: ▪ *Functional R39 539. ▪ Vascular R75 783. ▪ Pacemaker (single and dual chamber) R75 770. ▪ Spinal including artificial disc R70 418. ▪ Drug-eluting stents R22 983. ▪ Mesh R22 983. ▪ Gynaecology/urology R17 237. ▪ Lens implants R14 738 a lens per eye. ▪ Joint replacements: - Hip replacement and other major joints R63 201. - Knee replacement R73 615. - Other minor joints R27 219.	Sub-limits per beneficiary per annum: ▪ *Functional R43 932. ▪ Vascular R75 783. ▪ Pacemaker (single and dual chamber) R75 770. ▪ Spinal including artificial disc R81 308. ▪ Drug-eluting stents R27 077. ▪ Mesh R23 845. ▪ Gynaecology/urology R19 679. ▪ Lens implants R21 790 a lens per eye. ▪ Joint replacements: - Hip replacement and other major joints R72 755. - Knee replacement R84 245. - Other minor joints R27 077.
Exclusions (Prosthesis sub-limits form part of overall Internal prosthesis subject to preferred provider, otherwise limits and co-payments apply)	Joint replacement surgery (except for PMBs). PMBs subject to prosthesis limits: ▪ Hip replacement and other major joints R40 506. ▪ Knee replacement R53 866. ▪ Other minor joints R16 735.	Not applicable.		
Prosthesis – External	Limited to R27 723 per family per annum.	Limited to R33 037 per family per annum.	Limited to R33 182 per family per annum.	Limited to R37 491 per family per annum.
Orthopaedic and medical appliances **Note: Appliances directly relating to the hospital admission and/or procedure**	100% Scheme tariff. Limited to R15 000 per family per annum. Subject to PMB level of care.			
Pathology	100% Scheme tariff.			
Basic radiology	100% Scheme tariff.			
Specialised diagnostic imaging - in and/or out of hospital (including MRI scans, CT scans and nuclear/ isotope studies). **PET scans only included as indicated per benefit option.**	100% Scheme tariff. Limited to a combined in- and out-of-hospital benefit of R40 000 per family per annum. Co-payment of R2 000 per scan on, not applicable for PMBs. PET scans are limited to one (1) scan per beneficiary per annum, not subject to the abovementioned limit and co-payment. Subject to pre-authorisation.	100% Scheme tariff. Limited to a combined in- and out-of-hospital benefit of R42 000 per family per annum. Co-payment of R1 500 per scan on, not applicable for PMBs. PET scans are limited to one (1) scan per beneficiary per annum, not subject to the abovementioned limit and co-payment. Subject to pre-authorisation.		100% Scheme tariff. Limited to a combined in- and out-of-hospital benefit of R45 000 per family per annum. Co-payment of R1 500 per scan, not applicable for PMBs. PET scans are limited to one (1) scan per beneficiary per annum, not subject to the abovementioned limit and co-payment. Subject to pre-authorisation.
Oncology	Oncology programme. 100% of Scheme tariff. Subject to pre-authorisation, protocols and DSP.		Oncology programme. 100% of Scheme tariff. Subject to pre-authorisation and DSPs. Access to extended protocols.	
Breast surgery for cancer	Treatment of the **unaffected (non-cancerous) breast** will be limited to PMB provisions and is subject to pre-authorisation and funding guidelines.			
Medically necessary breast reduction surgery (including fees for the surgeon and anaesthetist)	No benefit			100% Scheme tariff. R58 046 per family per annum. Theatre and hospital cost will be funded from Scheme risk. Subject to funding protocols, pre-authorisation.
Peritoneal dialysis and haemodialysis	100% Scheme tariff. Subject to pre-authorisation and DSPs.			
HIV/AIDS	100% Scheme tariff. Subject to pre-authorisation and DSPs.			
Confinements (birthing)	100% Scheme tariff.			
Refractive surgery and other procedures done to improve or stabilise vision (except cataracts)	100% Scheme tariff. Subject to pre-authorisation and protocols. Limited to R10 859 per eye.	100% Scheme tariff. Subject to pre-authorisation and protocols. Limited to R11 347 per eye.	100% Scheme tariff. Subject to pre-authorisation and protocols. Limited to R12 210 per eye.	
Midwife-assisted births	100% Scheme tariff.			

	PACE1	PACE2	PACE3	PACE4
Supplementary services	100% Scheme tariff.			
Alternative to hospitalisation (i.e. procedures done in the doctor's rooms)	100% Scheme tariff.			
Advanced illness benefit	100% Scheme tariff, limited to R87 068 per beneficiary per annum. Subject to available benefit, pre-authorisation and treatment plan.	100% Scheme tariff, limited to R139 308 per beneficiary per annum. Subject to available benefit, pre-authorisation and treatment plan.		
Day procedures	Day procedures performed in a day hospital by a DSP provider will be funded at 100% network or Scheme, tariff subject to: pre-authorisation; protocols and funding guidelines; and DSPs. A co-payment of R2 746 will be incurred per event if a day procedure is done in an acute hospital that is not a day hospital. If a DSP is used and the DSP does not work in a day hospital, the procedure shall be paid in full if it is done in an acute hospital, if it is arranged with the Scheme before the time.			
International medical travel cover	▪ Holiday travel: Limited to 90 days and R5 000 000 per family, i.e. members and dependants. Limited to R1 000 000 per family for travel to the USA. ▪ Business travel: Limited to 60 days and R5 000 000 per family, i.e. members and dependants. Limited to R1 000 000 per family for travel to the USA.			

Out-of-hospital benefits

Note: Benefits below may be subject to pre-authorisation, clinical protocols, preferred providers, designated service providers (DSPs), formularies, funding guidelines and the Mediscor Reference Price (MRP).

Members are required to obtain pre-authorisation for all planned treatments and/or procedures, PMB services and chronic medication. Approved PMBs will be paid from Scheme risk.

	PACE1	PACE2	PACE3	PACE4
Overall day-to-day limit	M = R13 187, M1+ = R26 373.	M = R16 475, M1+ = R32 949.	M = R22 015, M1+ = R45 497.	M = R43 380, M1+ = R69 954.
GP, nurse and specialist consultations	Savings first. Limited to M = R2 715, M1+ = R5 459. (Subject to overall day-to-day limit)	Savings first. Limited to M = R5 029, M1+ = R10 192. (Subject to overall day-to-day limit)	Savings first. Limited to M = R5 316, M1+ = R10 773. (Subject to overall day-to-day limit)	Limited to M = R6 823, M1+ = R11 061. (Subject to overall day-to-day limit)
Basic and specialised dentistry	Savings first. **Basic:** Preventative benefit or savings account. Limit once savings exceeded.**Specialised:** Savings account then limit. **Orthodontic:** Subject to pre-authorisation. Limited to M = R4 998, M1+ = R10 142. (Subject to overall day-to-day limit)	Savings first. **Basic:** Preventative benefit or savings account. Limit once savings exceeded.**Specialised:** Savings account then limit. **Orthodontic:** Subject to pre-authorisation. Beneficiaries over 18 years of age. Limited to M = R8 377, M1+ = R16 756. (Subject to overall day-to-day limit)	Savings first. **Basic:** Preventative benefit or savings account. Limit once savings exceeded. **Specialised:** Savings account then limit. **Orthodontic:** Subject to pre-authorisation. Beneficiaries over 18 years of age. Limited to M = R9 027, M1+ = R16 829. (Subject to overall day-to-day limit)	Limited to M = R15 066, M1+ = R25 428. (Subject to overall day-to-day limit) **Orthodontic:** Subject to pre-authorisation. Beneficiaries over 18 years of age.
Orthodontic dentistry	Per the benefits specified for Pace1 under Basic and specialised dentistry.	Savings first. 100% Scheme tariff. Subject to pre-authorisation. Limited to R8 126 per event for beneficiaries up to 18 years of age. (Subject to overall day-to-day limit)	Savings first. 100% Scheme tariff. Subject to pre-authorisation. Limited to R10 448 per event for beneficiaries up to 18 years of age. (Subject to overall day-to-day limit)	100% Scheme tariff. Subject to pre-authorisation. Limited to R12 770 per event for beneficiaries up to 18 years of age. (Subject to overall day-to-day limit)
Medical aids, apparatus and appliances	Savings first. 100% Scheme tariff. Limited to R13 934 per family. Includes repairs to artificial limbs. (Subject to overall day-to-day limit).	Savings first. Limited to R12 640 per family. Includes repairs to artificial limbs. (Subject to overall day-to-day limit).		Limited to R12 640 per family. Includes repairs to artificial limbs. (Subject to overall day-to-day limit).
Wheel chairs	Subject to medical apparatus and appliance limits.	Limit on wheelchairs of R17 094 per family per 48 months.		
Hearing aids (Subject to pre-authorisation)	Limited to R9 678 per family every 24 months. 100% Scheme tariff. Subject to quotation, motivation and audiogram.	Limited to R32 000 per beneficiary every 24 months. Subject to quotation, motivation and audiogram.		Limited to R35 000 per beneficiary every 24 months. Subject to quotation, motivation and audiogram.
Insulin pump (excluding consumables)	No benefit.			100% Scheme tariff. Limited to R50 806 per beneficiary every 24 months. Subject to pre-authorisation.

	PACE1	PACE2	PACE3	PACE4
Continuous/Flash Glucose Monitoring (CGM/FGM)	Refer to medical aids, apparatus and appliances limit listed above.		100% Scheme tariff. Limited to R23 218 per family per annum. Subject to pre-authorisation.	100% Scheme tariff. Limited to R29 022 per family per annum. Subject to pre-authorisation.
Supplementary services	Savings first. Limited to M = R5 329, M1+ = R11 061. (Subject to overall day-to-day limit)	Savings first. Limited to M = R3 844, M1+ = R7 688. (Subject to overall day-to-day limit)	Savings first. Limited to M = R3 247, M1+ = R6 823. (Subject to overall day-to-day limit)	Limited to M = R6 823, M1+ = R13 430. (Subject to overall day-to-day limit)
Wound care benefit (incl. dressings, negative pressure wound therapy -NPWT- treatment and related nursing services – out-of-hospital)	Savings first. 100% Scheme tariff. Limited to R4 381 per family. (Subject to overall day-to-day limit)	Savings first. 100% Scheme tariff. Limited to R7 882 per family. (Subject to overall day-to-day limit)	Savings first. 100% Scheme tariff. Limited to R10 983 per family. (Subject to overall day-to-day limit)	Limited to R16 663 per family. (Subject to overall day-to-day limit)
Optometry benefit	Benefits available every 24 months from date of service. **Network Provider (PPN)** Consultation - One (1) per beneficiary. Frame = R1 210 covered AND 100% of cost of standard lenses (single vision OR bifocal OR multifocal) OR Contact lenses = R2 025 OR **Non-network Provider** Consultation - R400 fee at non-network provider Frame = R908 AND Single vision lenses = R215 OR Bifocal lenses = R460 OR Multifocal lenses = R1 040 (consisting of R810 per base lens plus R230 per branded lens add-on) In lieu of glasses members can opt for contact lenses, limited to R2 025	Benefits available every 24 months from date of service. **Network Provider (PPN)** Consultation - One (1) per beneficiary. Frame = R1 260 covered AND 100% of cost of standard lenses (single vision OR bifocal OR multifocal) AND Lens enhancement = R750 covered OR Contact lenses = R2 215 OR **Non-network Provider** Consultation - R400 fee at non-network provider Frame = R945 AND Single vision lenses = R215 OR Bifocal lenses = R460 OR Multifocal lenses = R1 040 (consisting of R810 per base lens plus R230 per branded lens add-on) AND Lens enhancements = R563 covered In lieu of glasses members can opt for contact lenses, limited to R2 215		Benefits available every 24 months from date of service. **Network Provider (PPN)** Consultation - One (1) per beneficiary. Frame = R1 260 covered AND 100% of cost of standard lenses (single vision OR bifocal OR multifocal) AND Lens enhancement = R750 covered OR Contact lenses = R2 620 OR **Non-network Provider** Consultation - R400 fee at non-network provider Frame = R945 AND Single vision lenses = R215 OR Bifocal lenses = R460 OR Multifocal lenses = R1 040 (consisting of R810 per base lens plus R230 per branded lens add-on) Lens enhancement = R563 covered In lieu of glasses members can opt for contact lenses, limited to R2 620
Basic radiology and pathology	Savings first. 100% Scheme tariff. Limited to M = R3 950, M1+ = R7 901. (Subject to overall day-to-day limit)		Savings first. 100% Scheme tariff. Limited to M = R4 310, M1+ = R8 546. (Subject to overall day-to-day limit)	100% Scheme tariff. Limited to M = R6 823, M1+ = R13 430. (Subject to overall day-to-day limit)
Specialised diagnostic imaging - in and/or out of hospital (including MRI scans, CT scans and nuclear/isotope studies). PET scans only included as indicated per benefit option.	100% Scheme tariff. Limited to a combined in- and out-of hospital benefit of R40 000 per family per annum. Co-payment of R2 000 per scan, except for an involuntary use of a non-DSP for a PMB condition. PET scans are limited to one (1) scan per beneficiary per annum, not subject to the abovementioned limit and co-payment. Subject to pre-authorisation.	100% Scheme tariff. Limited to a combined in- and out-of hospital benefit of R42 000 per family per annum. Co-payment of R1 500 per scan, except for an involuntary use of a non-DSP for a PMB condition. PET scans are limited to one (1) scan per beneficiary per annum, not subject to the abovementioned limit and co-payment. Subject to pre-authorisation.		100% Scheme tariff. Limited to a combined in- and out-of hospital benefit of R45 000 per family per annum. Co-payment of R1 500 per scan, except for an involuntary use of a non-DSP for a PMB condition. PET scans are limited to one (1) scan per beneficiary per annum, not subject to the abovementioned limit and co-payment. Subject to pre-authorisation.
Rehabilitation services after trauma	100% Scheme tariff.			
Back and neck preventative programme	Benefits payable at 100% of contracted fee. Subject to pre-authorisation, protocols and DSPs.			
HIV/AIDS	100% Scheme tariff. Subject to pre-authorisation and DSPs.			
Oncology	Oncology programme. 100% of Scheme tariff. Subject to pre-authorisation, protocols and DSP.		100% of Scheme tariff. Subject to pre-authorisation, protocols and DSP.	
Peritoneal dialysis and haemodialysis	100% Scheme tariff. Subject to pre-authorisation and DSPs.			

Medicine benefits

Benefits mentioned below may be subject to pre-authorisation, clinical protocols, preferred providers, designated service providers (DSPs), formularies, funding guidelines, the Mediscor Reference Price (MRP) and the exclusions referred to in Annexure C of the registered Rules.

Note: Approved CDL, PMB and non-CDL chronic medicine costs will be paid from the non-CDL chronic medicine limit first. Thereafter, approved CDL and PMB chronic medicine costs will continue to be paid (unlimited) from Scheme risk.

Members will not incur co-payments for approved PMB medications that are on the formulary for which there is no generic alternative.

Note: Approved PMB biological and non-PMB biological medicine costs will be paid from the biological limit first. Once the limit is depleted, only PMB biological medicine costs will continue to be paid unlimited from Scheme risk.

	PACE1	PACE2	PACE3	PACE4
CDL & PMB chronic medicine*	100% Scheme tariff. Co-payment of 25% for non-formulary medicine.	100% Scheme tariff. Co-payment of 20% for non-formulary medicine.	100% Scheme tariff. Co-payment of 15% for non-formulary medicine.	100% Scheme tariff. Co-payment of 10% for non-formulary medicine.
Non-CDL chronic medicine	7 conditions. 90% Scheme tariff. Limited to M = R8 044, M1+ = R16 087. Co-payment of 25% for non-formulary medicine.	20 conditions. 90% Scheme tariff. Limited to M = R10 983, M1+ = R21 966. Co-payment of 20% for non-formulary medicine.	20 conditions. 90% Scheme tariff. Limited to M = R16 878, M1+ = R33 757. Co-payment of 15% for non-formulary medicine.	29 conditions. 100% Scheme tariff. Limited to M = R24 058, M1+ = R48 335. Co-payment of 10% for non-formulary medicine.
Biologicals and other high cost medicine	PMBs only as per funding protocol. Subject to pre-authorisation. 100% Scheme tariff.	Subject to pre-authorisation. 100% Scheme tariff. Limited to R200 964 per beneficiary per year.	Subject to pre-authorisation. 100% Scheme tariff. Limited to R402 194 per beneficiary per year.	Subject to pre-authorisation. 100% Scheme tariff. Limited to R595 247 per beneficiary per year.
Acute medicine	Savings first. Limited to M = R2 846, M1+ = R5 890. (Subject to overall day-to-day limit).	Savings first. Limited to M = R3 295, M1+ = R6 590. (Subject to overall day-to-day limit).	Savings first. Limited to M = R2 197, M1+ = R4 942. (Subject to overall day-to-day limit).	Limited to M = R10 260, M1+ = R15 938. (10% co-payment) (Subject to overall day-to-day limit).
Over-the-counter (OTC) medicine Includes sunscreen, vitamins and minerals with NAPPI codes on Scheme formulary	**Member choice: 1. R1 161 OTC limit per family OR 2. Access to full savings for OTC purchases (after R1 161 limit) = self-payment gap accumulation. Subject to available savings.			Savings account.

*For all Pace options, approved medicines for the following conditions are not subject to the non-CDL limit: organ transplant, chronic renal failure, multiple sclerosis, haemophilia. Medicine claims will be paid directly from Scheme risk.
**The default OTC choice is 1. R1 161 OTC limit. Members wishing to choose the self-payment gap accumulation option are welcome to contact Bestmed.

Preventative care benefits

Note: Benefits mentioned below may be subject to pre-authorisation, clinical protocols, preferred providers, designated service providers (DSPs), formularies, funding guidelines and the Mediscor Reference Price (MRP).

	PACE1	PACE2	PACE3	PACE4
Preventative care **Note: Refer to Scheme rules for funding criteria applicable to each preventative care benefit.**	▪ Flu vaccines. ▪ Pneumonia vaccines. ▪ Travel vaccines. ▪ Paediatric immunisations. ▪ Three baby growth and development assessments per year for children 0-2 years. ▪ Female contraceptives – R2 678 per beneficiary per year. ▪ Intrauterine device (IUD) insertion (consultation and procedure) by a GP or gynaecologist. Once every 5 years. ▪ Preventative dentistry. ▪ Mammogram – females ages 40 and above, once every 24 months. ▪ HPV vaccinations. ▪ Pap smear (procedure and consultation) – age 18 and above, every 24 months. ▪ PSA screening – males ages 50 and above, every 24 months.	▪ Flu vaccines. ▪ Pneumonia vaccines. ▪ Travel vaccines. ▪ Paediatric immunisations. ▪ Three baby growth and development assessments per year for children 0-2 years. ▪ Female contraceptives – R2 678 per beneficiary per year. ▪ Intrauterine device (IUD) insertion (consultation and procedure) by a GP or gynaecologist. Once every 5 years. ▪ Preventative dentistry. ▪ Mammogram – females ages 40 and above, once every 24 months. ▪ PSA screening – males ages 50 and above, every 24 months. ▪ HPV vaccinations. ▪ Bone densitometry. ▪ Pap smear (procedure and consultation) – ages 18 and above, every 24 months. ▪ Glaucoma screening - ages 50 and above, once every 12 months. The benefit is subject to service being received from the contracted Optometrist Network only.		

	PACE1	PACE2	PACE3	PACE4
PREVENTATIVE DENTISTRY				
General full-mouth examination by a general dentist (incl. gloves and use of sterile equipment)	Once a year for members 12 years and above. Twice a year for members under 12 years.			
Full-mouth intra-oral radiographs	Once every 36 months for all ages.			
Intra-oral radiograph	Two (2) photos per year for all ages.			
Scaling and/or polishing	Twice per year (i.e. every 6 months from the date of service) for all ages.			
Fluoride treatment	Twice per year (i.e. every 6 months from the date of service) for all ages.			
Fissure sealing	Up to and including 21 years. Frequency must be in accordance with accepted protocol.			
Space maintainers	Once per space during the primary and mixed denture stage.			

Disclaimer on exclusions: General and option-specific exclusions apply. Please refer to www.bestmed.co.za for more details.

Maternity benefits

Note: Benefits mentioned below may be subject to registration, preferred providers, designated service providers (DSPs), formularies, funding guidelines and the Mediscor Reference Price (MRP).

PACE1	PACE2	PACE3	PACE4
100% Scheme tariff. Subject to the following benefits: **Consultations:** ▪ 9 antenatal consultations at a GP OR gynaecologist OR midwife. ▪ 1 post-natal consultation at a GP OR gynaecologist OR midwife. **Ultrasounds:** ▪ 1 x 2D ultrasound scan at 1st trimester (between 10 to 12 weeks) at a GP OR gynaecologist OR radiologist. ▪ 1 x 2D ultrasound scan at 2nd trimester (between 20 to 24 weeks) at a GP OR gynaecologist OR radiologist. **Supplements:** ▪ Any item categorised as a maternity supplement can be claimed up to a maximum of R139 per claim, once a month, for a maximum of 9 months.			

Contributions

		PACE1	PACE2	PACE3	PACE4
Medical Savings Account		**19%**	**14%**	**14%**	**3%**
Principal Member	Risk	R4 622	R6 993	R8 029	R11 312
	Savings	R1 085	R1 139	R1 307	R350
	Total	**R5 706**	**R8 132**	**R9 336**	**R11 662**
Adult Dependant	Risk	R3 247	R6 857	R6 463	R11 312
	Savings	R761	R1 116	R1 052	R350
	Total	**R4 008**	**R7 974**	**R7 515**	**R11 662**
Child Dependant	Risk	R1 166	R1 541	R1 381	R2 650
	Savings	R274	R251	R224	R82
	Total	**R1 440**	**R1 793**	**R1 606**	**R2 732**
Maximum contribution child dependant*		3			
Recognition of a child dependant		Dependants under the age of 24 years are regarded as child dependants.			

*You only pay for a maximum of three children. Any additional children join as beneficiaries of the Scheme at no additional cost.

ABBREVIATIONS

DBC = Documentation Based Care (Back Rehabilitation Programme); DSP = Designated Service Provider; GP = General Practitioner or Doctor; HPV = Human Papilloma Virus; M = Member; M1+ = Member and family; MRI/CT scans = Magnetic Resonance Imaging/Computed Tomography scans; MRP = Mediscor Reference Price; NP = Network Provider; PET scan = Positron Emission Tomography scan; PMB = Prescribed Minimum Benefits; PPN = Preferred Provider Negotiators; PSA = Prosate Specific Antigen.

Rhythm

RHYTHM IS IDEALLY SUITABLE FOR YOU IF:

- You are seeking a plan option that is based on your income.
- You are comfortable with making use of designated service providers (DSPs) within our Rhythm network.
- You are looking for unlimited comprehensive cover for hospitalisation and the added benefit of preventative care.

Method of Scheme benefit payment

RHYTHM1 AND RHYTHM2

- In-hospital benefits are paid from Scheme risk.
- Some preventative care benefits are available from Scheme risk.
- Some out-of-hospital benefits are paid from Scheme risk.
- Benefits relating to conditions that meet the criteria for PMBs will be covered in full when using DSPs.

In-hospital benefits

Benefits relating to conditions that meet the criteria for PMBs will be covered in full when using DSPs, and this will not affect your savings.

Note: All the below benefits are subject to pre-authorisation and clinical protocols.

All members must obtain pre-authorisation for planned procedures at least 14 (fourteen) days before the event. However, in the case of an emergency, you, your representative or the hospital must notify Bestmed of your hospitalisation as soon as possible or on the first working day after admission to hospital.

	RHYTHM1	RHYTHM2
Accommodation (hospital stay) and theatre fees	Approved PMBs at DSPs.	100% Scheme tariff at a DSP hospital.
Take-home medicine	100% of Scheme tariff, limited to a maximum of 7 days treatment provided that: ▪ the medicine is claimed as part of the hospital account; or ▪ R150 if medicine is claimed from a retail pharmacy on the date of discharge; and ▪ subject to MRP. No benefit if not claimed on the date of discharge.	100% of Scheme tariff, limited to a maximum of 7 days treatment provided that: ▪ the medicine is claimed as part of the hospital account; or ▪ R150 if medicine is claimed from a retail pharmacy on the date of discharge; and ▪ subject to MRP. No benefit if not claimed on the date of discharge.
Biological medicine during hospitalisation	Approved PMBs at DSPs.	Limited to R17 414 per family per annum. Subject to pre-authorisation and funding guidelines.
Treatment in mental health facilities	Approved PMBs at DSPs. Limited to a maximum of 21 days per beneficiary per financial year in hospital including inpatient electro-convulsive therapy and inpatient psychotherapy, OR 15 contact sessions for out-patient psychotherapy per beneficiary per financial year. Subject to pre-authorisation.	100% Scheme tariff. Limited to a maximum of 21 days per beneficiary per financial year, including inpatient electro-convulsive therapy and inpatient psychotherapy, OR 15 contact sessions for outpatient psychotherapy per beneficiary per financial year. Subject to pre-authorisation and DSPs.
Treatment of chemical and substance abuse	Benefits shall be limited to the treatment of PMB conditions and subject to the following: ▪ Pre-authorisation ▪ DSPs ▪ 21 days' stay for in-hospital management per beneficiary per annum.	
Consultations and procedures	Approved PMBs at DSPs. Subject to pre-authorisation.	100% Scheme tariff. Subject to pre-authorisation and DSP network.
Surgical procedures and anaesthetics	Approved PMBs at DSPs. Subject to pre-authorisation.	100% Scheme tariff. Subject to pre-authorisation and DSP network.
Organ transplants	100% Scheme tariff (PMBs only).	
Stem cell transplants	100% Scheme tariff (PMBs only).	
Major maxillofacial surgery, strictly related to certain conditions	Approved PMBs at DSPs.	Approved PMBs at DSPs.
Dental and oral surgery (in or out of hospital)	Approved PMBs at DSPs.	Approved PMBs at DSPs.
Overall annual prosthesis limit	100% Scheme tariff. Limited to R64 208 per family. Subject to PMBs at DSP network.	100% Scheme tariff. Limited to R64 208 per family. Subject to preferred providers or DSPs.
Prosthesis – Internal **Note: Sub-limits subject to availability of overall prosthesis limit.** ***Functional: Items used to replace or augment an impaired bodily function.**	Sub-limits per beneficiary per annum: ▪ *Functional R34 047. ▪ Vascular R54 915. ▪ Pacemaker (single and dual chamber) R51 998. ▪ Spinal including artificial disc R31 815. ▪ Drug-eluting stents – subject to Vascular prosthesis limit. DSPs apply. ▪ Mesh R11 636. ▪ Gynaecology/urology R9 611. ▪ Lens implants R6 681 a lens per eye.	

	RHYTHM1	RHYTHM2
Exclusions (Prosthesis sub-limits form part of overall Internal prosthesis subject to preferred provider, otherwise limits and co-payments apply)	Joint replacement surgery (except for PMBs). PMBs subject to prosthesis limits: ▪ Hip replacement and other major joints R32 607. ▪ Knee replacement R41 226. ▪ Minor joints R15 441. Functional nasal surgery and surgical procedures where CNS stimulators are used (e.g. epilepsy, Parkinson disease, etc.) will be excluded from benefits, except for PMB conditions.	
Prosthesis – External	Approved PMBs at DSPs.	
Breast surgery for cancer	Treatment of the **unaffected (non-cancerous) breast** will be limited to PMB provisions and is subject to pre-authorisation and funding guidelines.	
Orthopaedic and medical appliances Note: Appliances directly relating to the hospital admission and/or procedure	Approved PMBs at DSPs.	100% Scheme tariff. Limited to R7 901 per family per annum. Subject to PMB level of care.
Basic radiology and pathology	Approved PMBs at DSPs.	100% Scheme tariff.
Specialised diagnostic imaging - in and/ or out of hospital (including MRI scans, CT scans and nuclear/ isotope studies). PET scans only included as indicated per benefit option.	Approved PMBs at DSPs. PET scans - PMB only. Subject to pre-authorisation.	100% Scheme tariff. Limited to a combined in- and out-of-hospital benefit of R18 000 per family per annum. Co-payment of R2 600 per scan, not applicable to PMBs. PET scans - PMB only. Subject to pre-authorisation.
Oncology	Approved PMBs at DSPs.	Oncology programme. 100% Scheme tariff. Subject to pre-authorisation, protocols and DSP.
Peritoneal dialysis and haemodialysis	Approved PMBs at DSPs.	100% Scheme tariff. Subject to pre-authorisation, protocols and DSP.
Confinements (birthing)	Approved PMBs at DSPs.	100% Scheme tariff.
Midwife-assisted births	PMBs and emergency caesarean sections (C-sections).	100% Scheme tariff. Subject to pre-authoristation, DSPs, protocols and funding guidelines.
Refractive surgery and other procedures done to improve or stabilise vision (except cataracts)	Approved PMBs at DSPs.	Approved PMBs at DSPs.
Supplementary services	Approved PMBs at DSPs.	100% Scheme tariff.
HIV/AIDS	Approved PMBs at DSPs.	100% Scheme tariff. Subject to pre-authorisation, protocols and DSP.
Alternative to hospitalisation (i.e. procedures done in the doctor's rooms)	Approved PMBs at DSPs.	100% Scheme tariff. Subject to pre-authorisation and DSPs or preferred providers.
Advanced illness benefit	Approved PMBs. Subject to pre-authorisation and treatment plan.	100% Scheme tariff. Limited to R69 654 per beneficiary per annum. Subject to available benefit, pre-authorisation and treatment plan.
Day procedures	**PMBs in network day hospitals:** Approved PMBs at DSPs. Subject to pre-authorisation, protocols and funding guidelines. **Non-PMBs in network day-hospitals:** 100% Scheme tariff. Subject to approved DSPs and pre-authorisation. Limited to R54 915 per family per annum for non-PMB day procedures. A R2 746 co-payment will be incurred per event if a day procedure is done in an acute hospital that is not a day hospital. If a DSP is used and the DSP does not work in a day hospital, the procedure shall be paid in full if it is done in an acute hospital, if it is arranged with the Scheme before the time. The non-PMB conditions covered are: ▪ Circumcision ▪ Colonoscopy - co-payment applicable ▪ Gastroscopy - co-payment applicable ▪ Myringotomy and grommet insertion ▪ Sterilisation (male and female) ▪ Tonsillectomy	Day procedures performed in a day hospital by a DSP provider will be funded at 100% network or Scheme tariff, subject to pre-authorisation, protocols, funding guidelines and DSPs. A R2 746 co-payment will be incurred per event if a day procedure is done in an acute hospital that is not a day hospital. If a DSP is used and the DSP does not work in a day hospital, the procedure shall be paid in full if it is done in an acute hospital, if it is arranged with the Scheme before the time.
International medical travel cover	▪ Holiday travel: Limited to 90 days and R5 000 000 per family, i.e. members and dependants. Limited to R1 000 000 per family for travel to the USA. ▪ Business travel: Limited to 60 days and R5 000 000 per family, i.e. members and dependants. Limited to R1 000 000 per family for travel to the USA.	

	RHYTHM1	RHYTHM2
Co-payments	**Non-network hospital co-payment:** Co-payment of R14 364 per event for voluntary use of a non-DSP hospital. **Procedure-specific co-payments:** The co-payment shall not apply to PMB conditions: ▪ Colonoscopies R2 000. ▪ Gastroscopies R2 000. A R2 746 co-payment, as described in the Day procedures benefit, will be incurred per event if a day procedure is done in an acute hospital that is not a day hospital.	**Non-network hospital co-payment:** Co-payment of R14 364 per event for voluntary use of a non-DSP hospital. **Procedure-specific co-payments:** The co-payment shall not apply to PMB conditions: ▪ Arthroscopic procedures R3 660. ▪ Back and neck surgery R3 660. ▪ Laparoscopic procedures R3 660. ▪ Colonoscopies R2 000. ▪ Cystoscopies R2 000. ▪ Gastroscopies R2 000. ▪ Hysteroscopies R2 000. ▪ Sigmoidoscopies R2 000. ▪ Extraction of wisdom teeth R2 500. A R2 746 co-payment, as described in the Day procedures benefit, will be incurred per event if a day procedure is done in an acute hospital that is not a day hospital.

Out-of-hospital benefits

Note: Benefits under the primary care services and the Scheme benefits shall be subject to treatment protocols, preferred providers, designated service providers (DSPs), dental procedure codes, pathology and radiology lists of codes and medicine formularies, funding guidelines and the Mediscor Reference Price (MRP) as accepted by the Scheme.

Members are required to obtain pre-authorisation for all planned treatments and/or procedures, PMB services and chronic medication.

	RHYTHM1	RHYTHM2
Overall day-to-day limit	N/A	N/A
GP consultations	Unlimited GP consultations. Subject to Bestmed Rhythm GP network. Pre-approval required after 10th visit. Applicable per family per annum.	Unlimited GP consultations. Subject to Bestmed Rhythm GP network. Applicable per family per annum.
Pharmacy clinic nurse consultations	100% of Scheme tariff. Unlimited primary care nurse consultations (NAPPI code 981078001) at network pharmacies.	No benefit
Casualty and out-of-network GP visits	PMBs only.	100% Scheme tariff. Limited to R1 723 per family.
Specialist consultations	Specialist consultations must be referred by a Rhythm Network Provider. 100% Scheme tariff. Limited to R2 553 per family per year. Subject to Rhythm Specialist Network.	Specialist consultations must be referred by a Rhythm Network Provider. Limited to M = R1 742, M1+ = R2 903. Subject to Rhythm Specialist Network.
Basic and specialised dentistry	Basic dentistry: Subject to Bestmed Rhythm Dental Network Providers. Specialised dentistry: No benefit.	
Medical aids, apparatus and appliances	PMB only.	
Wheelchairs	PMB only.	
Hearing aids	Approved PMBs at DSPs.	
Supplementary services	PMB only.	
Wound care benefit (incl. dressings, negative pressure wound therapy treatment -NPWT- and related nursing services – out-of-hospital)	PMB only.	
Optometry benefit	Benefits available every 24 months from date of service. **Network Provider (PPN)** One (1) consultation (eye test) at optometrist network per beneficiary per annum. No benefit for spectacle frames, lenses or contact lenses. **Non-network Provider** One (1) consultation per beneficiary = R400 No benefit for spectacle frames, lenses or contact lenses.	Benefits available every 24 months from date of service. **Network Provider (PPN)** One (1) consultation per beneficiary. Frame = R295 covered AND 100% of cost of standard lenses (single vision OR bifocal OR multifocal) OR Contact lenses = R770

	RHYTHM1	RHYTHM2
Basic radiology and pathology	100% Scheme tariff. Referral by Bestmed Rhythm Network GP or Rhythm Specialist DSP. Subject to Bestmed Rhythm protocols and approved radiology and pathology codes.	
Specialised diagnostic imaging - in and/or out of hospital (including MRI scans, CT scans and nuclear/isotope studies). **PET scans only included as indicated per benefit option.**	Approved PMBs at DSPs. PET scans - PMB only. Subject to pre-authorisation.	100% Scheme tariff. Limited to a combined in- and out-of-hospital benefit of R18 000 per family per annum. Co-payment of R2 600 per scan, not applicable to PMBs. PET scans - PMB only. Subject to pre-authorisation.
Rehabilitation services after trauma	PMBs only. Subject to pre-authorisation and DSPs.	
Back and neck preventative programme	Benefits payable at 100% of contracted fee. Subject to pre-authorisation, protocols and DSPs.	
HIV/AIDS	Approved PMBs at DSPs.	Subject to pre-authorisation, protocols and DSP.
Oncology	Approved PMBs at DSPs.	Subject to pre-authorisation, protocols and DSP.
Peritoneal dialysis and haemodialysis	Approved PMBs at DSPs.	Subject to pre-authorisation, protocols and DSP.

Medicine benefits

Benefits mentioned below may be subject to pre-authorisation, clinical protocols, preferred providers, designated service providers (DSPs), formularies, funding guidelines, the Mediscor Reference Price (MRP) and the exclusions referred to in Annexure C of the registered Rules.

Members will not incur co-payments for approved PMB medications that are on the formulary for which there is no generic alternative.

	RHYTHM1	RHYTHM2
CDL & PMB chronic medicine	100% Scheme tariff. 30% co-payment for non-formulary medicine.	
Non-CDL chronic medicine	No benefit.	No benefit.
Biologicals and other high cost medicine	PMBs only, as per funding protocol. Subject to pre-authorisation.	
Acute medicine	100% Scheme tariff. Subject to Bestmed formulary.	
Over-the-counter (OTC) medicine **Includes sunscreen, vitamins and minerals with NAPPI codes on Scheme formulary**	100% Scheme tariff. Limited to R240 per family per annum and to R120 per event. Subject to preferred provider pharmacy network.	100% Scheme tariff. Limited to R350 per family per annum and to R120 per event. Subject to preferred provider pharmacy network.

Preventative care benefits

Note: Benefits mentioned below may be subject to pre-authorisation, clinical protocols, preferred providers, designated service providers (DSPs), Rhythm network, formularies, funding guidelines and the Mediscor Reference Price (MRP).

	RHYTHM1	RHYTHM2
Preventative care **Note: Refer to Scheme rules for funding criteria applicable to each preventative care benefit.**	▪ Flu vaccines. ▪ Pneumonia vaccines. ▪ Travel vaccines. ▪ Paediatric immunisations. ▪ Three baby growth and development assessments per year for children 0-2 years. ▪ Female contraceptives R2 000 per beneficiary per year. ▪ Intrauterine device (IUD) insertion (consultation and procedure) by a network GP or gynaecologist. Once every 5 years. ▪ Mammogram (tariff code 34100) – females ages 40 and above, every 24 months. Must be referred by a Bestmed Rhythm Network GP or Rhythm Specialist DSP. ▪ Pap smear (pathology only) – ages 18 and above, every 24 months.	▪ Flu vaccines. ▪ Pneumonia vaccines. ▪ Travel vaccines. ▪ Paediatric immunisations. ▪ Three baby growth and development assessments per year for children 0-2 years. ▪ Female contraceptives R2 200 per beneficiary per year. ▪ Intrauterine device (IUD) insertion (consultation and procedure) by a network GP or gynaecologist. Once every 5 years. ▪ HPV vaccinations (Females 9-26 years). ▪ Mammogram (tariff code 34100) – females ages 40 and above, every 24 months. Must be referred by a Bestmed Rhythm Network GP or Rhythm Specialist DSP. ▪ PSA Screening – males ages 50 years and above, every 24 months. ▪ Pap smear (pathology only) – ages 18 and above, every 24 months.

Disclaimer on exclusions: General and option specific exclusions apply. Please refer to www.bestmed.co.za for more details.

Maternity benefits

Note: Benefits mentioned below may be subject to registration, preferred providers, designated service providers (DSPs), formularies, funding guidelines and the Mediscor Reference Price (MRP).

RHYTHM1	RHYTHM2
100% Scheme tariff at DSP network. Subject to the following benefits: **Consultations:** ▪ 6 antenatal consultations at a GP OR gynaecologist OR midwife. **Ultrasounds:** ▪ 1 x 2D ultrasound scan at 1st trimester (between 10 to 12 weeks) at a GP OR gynaecologist OR radiologist. ▪ 1 x 2D ultrasound scan at 2nd trimester (between 20 to 24 weeks) at a GP OR gynaecologist OR radiologist.	**100% Scheme tariff at DSP network. Subject to the following benefits:** **Consultations:** ▪ 9 antenatal consultations at either a GP OR gynaecologist OR midwife. ▪ 1 post-natal consultation at either a GP OR gynaecologist OR midwife. **Ultrasounds:** ▪ 1 x 2D ultrasound scan at 1st trimester (between 10 to 12 weeks) at a GP OR gynaecologist OR radiologist. ▪ 1 x 2D ultrasound scan at 2nd trimester (between 20 to 24 weeks) at a GP OR gynaecologist OR radiologist. **Supplements:** ▪ Any item categorised as a maternity supplement can be claimed up to a maximum of R139 per claim, once a month, for a maximum of 9 months.

Contributions

		RHYTHM1		
Income level		R0 – R9 000 p.m.	R9 001 – R14 000 p.m.	> R14 001 p.m.
Medical Savings Account			**N/A**	
Principal Member	Risk	R1 615	R1 883	R3 363
	Savings	R0	R0	R0
	Total	**R1 615**	**R1 883**	**R3 363**
Adult Dependant	Risk	R1 615	R1 883	R3 363
	Savings	R0	R0	R0
	Total	**R1 615**	**R1 883**	**R3 363**
Child Dependant	Risk	R665	R800	R1 742
	Savings	R0	R0	R0
	Total	**R665**	**R800**	**R1 742**
Maximum contribution child dependant*		N/A	N/A	N/A
Recognition of a child dependant		Dependants under the age of 24 years are regarded as child dependants.		

		RHYTHM2		
Income level		R0 – R5 500 p.m.	R5 501 – R8 500 p.m.	> R8 501 p.m.
Medical Savings Account			**N/A**	
Principal Member	Risk	R2 368	R2 845	R3 413
	Savings	R0	R0	R0
	Total	**R2 368**	**R2 845**	**R3 413**
Adult Dependant	Risk	R2 250	R2 703	R3 072
	Savings	R0	R0	R0
	Total	**R2 250**	**R2 703**	**R3 072**
Child Dependant	Risk	R1 425	R1 707	R1 707
	Savings	R0	R0	R0
	Total	**R1 425**	**R1 707**	**R1 707**
Maximum contribution child dependant*			3	
Recognition of a child dependant		Dependants under the age of 24 years are regarded as child dependants.		

*You only pay for a maximum of three children. Any additional children join as beneficiaries of the Scheme at no additional cost.

ABBREVIATIONS

DBC = Documentation Based Care (Back Rehabilitation Programme); DSP = Designated Service Provider; GP = General Practitioner or Doctor; M = Member; M1+ = Member and family; MRI/CT scans = Magnetic Resonance Imaging/Computed Tomography scans; MRP = Mediscor Reference Price; NP = Network Provider; PET scan = Positron Emission Tomography scan; PMB = Prescribed Minimum Benefits; PSA = Prostate Specific Antigen; Preferred Provider Negotiators = PPN.

Co-payments and conditions lists

When do co-payments apply for medicine claims?

- If medicine is prescribed/selected for the treatment of a CDL, PMB or non–CDL condition and is not listed on the formulary.
- If the prescribed/selected medicine costs more than the Mediscor Reference Price (MRP).
- A formulary co-payment on non-CDL conditions is applicable depending on the chosen plan option.
- When the provider charges a higher dispensing fee than what the Scheme reimburses.

Please note that according to the Council for Medical Schemes (CMS) co-payments may not be deducted from your savings account or vested savings account or reimbursed to you.
The co–payment percentage varies according to the different benefit options. The table below highlights the different co–payments applicable per Scheme option for the CDL, PMB and non–CDL conditions:

Benefit	Beat1	Beat2	Beat3	Beat4	Pace1	Pace2	Pace3	Pace4	Rhythm1	Rhythm2
Non-formulary co-payment for CDL and PMB conditions	30%	30%	30%	20%	25%	20%	15%	10%	30%	30%
Formulary co-payment for non-CDL conditions	No benefit	No benefit	20%	10%	10%	10%	10%	0%	No benefit	No benefit
Non-formulary co-payment for non-CDL conditions	No benefit	No benefit	30%	20%	25%	20%	15%	10%	No benefit	No benefit

Chronic Conditions List

The Chronic Disease List (CDL) provides cover for the 27 listed chronic conditions for which medical schemes must cover the diagnosis, medical management and medicines as published by the Council for Medical Schemes. An additional 18 conditions are covered as Prescribed Minimum Benefits (PMB), where the medical management and medicines are also covered from Scheme benefits. Non-CDL chronic conditions are those additional conditions that Bestmed provides chronic medicine cover for. Authorisation for CDL, PMB and non-CDL chronic medicines is subject to clinical funding guidelines and protocols, formularies and Designated Service Providers (DSPs) where applicable. Approved CDL and PMB chronic medicines are covered without an annual financial limit while non-CDL chronic medicines are subject to an annual financial limit. Below is the list of CDL, PMB and non-CDL conditions that Bestmed covers on the various benefit options.

		BEAT1	BEAT2	BEAT3	BEAT4	PACE1	PACE2	PACE3	PACE4	RHYTHM1 & 2
Number of non-CDL conditions		0	0	5	9	7	20	20	29	0
Reimbursement for CDL & PMB		100% of Scheme tariff								
Reimbursement for non-CDL		N/A	N/A	80%	90%	90%	90%	90%	100%	N/A
Non-formulary co-payment for CDL and PMB conditions		30%	30%	30%	20%	25%	20%	15%	10%	30%
Formulary co-payment for non-CDL conditions		N/A	N/A	20%	10%	10%	10%	10%	0%	N/A
Non-formulary co-payment for non-CDL conditions		N/A	N/A	30%	20%	25%	20%	15%	10%	N/A
CDL										
CDL 1	Addison disease	√	√	√	√	√	√	√	√	√
CDL 2	Asthma	√	√	√	√	√	√	√	√	√
CDL 3	Bipolar disorder	√	√	√	√	√	√	√	√	√
CDL 4	Bronchiectasis	√	√	√	√	√	√	√	√	√
CDL 5	Cardiac failure	√	√	√	√	√	√	√	√	√
CDL 6	Cardiomyopathy	√	√	√	√	√	√	√	√	√
CDL 7	Chronic obstructive pulmonary disease (COPD)	√	√	√	√	√	√	√	√	√
CDL 8	Chronic renal disease	√	√	√	√	√	√	√	√	√
CDL 9	Coronary artery disease	√	√	√	√	√	√	√	√	√
CDL 10	Crohn disease	√	√	√	√	√	√	√	√	√
CDL 11	Diabetes insipidus	√	√	√	√	√	√	√	√	√
CDL 12	Diabetes mellitus type 1	√	√	√	√	√	√	√	√	√
CDL 13	Diabetes mellitus type 2	√	√	√	√	√	√	√	√	√
CDL 14	Dysrhythmias	√	√	√	√	√	√	√	√	√
CDL 15	Epilepsy	√	√	√	√	√	√	√	√	√
CDL 16	Glaucoma	√	√	√	√	√	√	√	√	√
CDL 17	Haemophilia	√	√	√	√	√	√	√	√	√
CDL 18	HIV/AIDS	√	√	√	√	√	√	√	√	√

		BEAT1	BEAT2	BEAT3	BEAT4	PACE1	PACE2	PACE3	PACE4	RHYTHM1 & 2
CDL 19	Hyperlipidaemia	√	√	√	√	√	√	√	√	√
CDL 20	Hypertension	√	√	√	√	√	√	√	√	√
CDL 21	Hypothyroidism	√	√	√	√	√	√	√	√	√
CDL 22	Multiple sclerosis	√	√	√	√	√	√	√	√	√
CDL 23	Parkinson disease	√	√	√	√	√	√	√	√	√
CDL 24	Rheumatoid arthritis	√	√	√	√	√	√	√	√	√
CDL 25	Schizophrenia	√	√	√	√	√	√	√	√	√
CDL 26	Systemic lupus erythematosus (SLE)	√	√	√	√	√	√	√	√	√
CDL 27	Ulcerative colitis	√	√	√	√	√	√	√	√	√
NON-CDL										
non-CDL 1	Acne - severe			√	√	√	√	√	√	
non-CDL 2	Allergic rhinitis			√	√	√	√	√	√	
non-CDL 3	Alzheimer disease						√	√	√	
non-CDL 4	Ankylosing spondylitis						√	√	√	
non-CDL 5	Attention deficit disorder/Attention deficit hyperactivity disorder (ADD/ADHD)			√	√	√	√	√	√	
non-CDL 6	Autism						√	√	√	
non-CDL 7	Blepharospasm								√	
non-CDL 8	Collagen diseases						√	√	√	
non-CDL 9	Dermatomyositis						√	√	√	
non-CDL 10	Dystonia								√	
non-CDL 11	Eczema			√	√	√	√	√	√	
non-CDL 12	Gastro-oesophageal reflux disease (GORD)				√		√	√	√	
non-CDL 13	Gout prophylaxis				√	√	√	√	√	
non-CDL 14	Hypopituitarism								√	
non-CDL 15	Major depression*				√	√	√	√	√	
non-CDL 16	Migraine prophylaxis			√	√	√	√	√	√	
non-CDL 17	Motor neuron disease								√	
non-CDL 18	Neuropathy						√	√	√	
non-CDL 19	Obsessive-compulsive disorder				√		√	√	√	

* Approved medicine claims will continue to be paid from Scheme risk once the non-CDL limit is depleted.

		BEAT1	BEAT2	BEAT3	BEAT4	PACE1	PACE2	PACE3	PACE4	RHYTHM1 & 2
non-CDL 20	Osteoarthritis						√	√	√	
non-CDL 21	Osteoporosis						√	√	√	
non-CDL 22	Paget disease of the bone						√	√	√	
non-CDL 23	Polyarteritis nodosa								√	
non-CDL 24	Psoriatic arthritis								√	
non-CDL 25	Psoriasis						√	√	√	
non-CDL 26	Urinary incontinence						√	√	√	
non-CDL 27	Scleroderma								√	
non-CDL 28	Sjögren's disease								√	
non-CDL 29	Trigeminal neuralgia								√	
PMB										
PMB 1	Aplastic anaemia	√	√	√	√	√	√	√	√	√
PMB 2	Benign prostatic hyperplasia	√	√	√	√	√	√	√	√	√
PMB 3	Cerebral palsy	√	√	√	√	√	√	√	√	√
PMB 4	Chronic anaemia	√	√	√	√	√	√	√	√	√
PMB 5	COVID-19	√	√	√	√	√	√	√	√	√
PMB 6	Cushing disease	√	√	√	√	√	√	√	√	√
PMB 7	Endometriosis	√	√	√	√	√	√	√	√	√
PMB 8	Female menopause	√	√	√	√	√	√	√	√	√
PMB 9	Fibrosing alveolitis	√	√	√	√	√	√	√	√	√
PMB 10	Graves disease	√	√	√	√	√	√	√	√	√
PMB 11	Hyperthyroidism	√	√	√	√	√	√	√	√	√
PMB 12	Hypophyseal adenoma	√	√	√	√	√	√	√	√	√
PMB 13	Idiopathic trombocytopenic purpura	√	√	√	√	√	√	√	√	√
PMB 14	Paraplegia/quadriplegia	√	√	√	√	√	√	√	√	√
PMB 15	Polycystic ovarian syndrome	√	√	√	√	√	√	√	√	√
PMB 16	Pulmonary embolism	√	√	√	√	√	√	√	√	√
PMB 17	Stroke	√	√	√	√	√	√	√	√	√

Contact details

CLIENT SERVICES
Tel: +27 (0)86 000 2378
Email: service@bestmed.co.za
Fax: +27 (0)12 472 6500

HIV/AIDS CARE PROGRAMME
Tel: +27 (0)12 472 6235/6249
Email: mhc@bestmed.co.za
Fax: +27 (0)12 472 6780

BESTMED HIV/AIDS MANAGED CARE ORGANISATION
LIFESENSE

Tel: +27 (0)86 050 6080
Email: enquiry@lifesense.co.za
Fax: +27 (0)86 080 4960

BESTMED DSP PHARMACIES
Please refer to the Bestmed website, www.bestmed.co.za, for network pharmacies in your area.

ONCOLOGY CARE PROGRAMME
Tel: +27 (0)12 472 6254/6234/6353
Email: oncology@bestmed.co.za
Fax: +27 (0)12 472 6770

COMPLAINTS
Tel: +27 (0)86 000 2378
Email: escalations@bestmed.co.za
(Subject box: Manager, escalated query)
Postal address:
PO Box 2297,
Pretoria, Gauteng, 0001

CMS ESCALATIONS
Should an issue remain unresolved with the Scheme, members can escalate to the Council for Medical Schemes (CMS) Registrar's office:

Fax Complaints: 086 673 2466.

Email Complaints: complaints@medicalschemes.co.za

Postal Address:
Private Bag X34, Hatfield, 0028

Physical Address:
Block A, Eco Glades 2 Office Park, 420 Witch-Hazel Avenue, Eco Park, Centurion, 0157

REGIONAL OFFICES

Pretoria (Head Office)
Tel: +27 (0)86 000 2378
Email: service@bestmed.co.za
Glenfield Office Park,
361 Oberon Avenue,
Faerie Glen, Pretoria, 0081

Cape Town
Tel: +27 (0)21 202 8808
Email: service@bestmed.co.za
Belvedere Office Park
Suite GE003, Portion Ground Floor
Block E, Bella Rosa Street
Bellville, Cape Town, 7550

Durban
Tel: +27 (0)31 279 5420
Email: service@bestmed.co.za
Unit 8, Office 1,
Pencarrow Park,
Pencarrow Crescent,
La Lucia Ridge, 4051

Gqeberha (Port Elizabeth)
Tel: +27 (0)41 363 8921
Email: service@bestmed.co.za
142 Cape Road, Mill Park,
Gqeberha, 6001

Nelspruit
Tel: +27 (0)13 101 0280
Email: service@bestmed.co.za
Crossing Office Block,
Level 1, Block E,
Crossing Shopping Centre,
Nelspruit, 1200.

Polokwane
Tel: +27 (0)86 000 2378
Email: service@bestmed.co.za
Unit 3 Tobara Place,
9 Watermelon Street,
Platinum Park, Bendor,
Polokwane, 0699

086 000 2378

service@bestmed.co.za

068 376 7212

012 472 6500

www.bestmed.co.za

Bestmed Medical Scheme

Bestmed Medical Scheme

HOSPITAL AUTHORISATION
Tel: 080 022 0106
Email: authorisations@bestmed.co.za

CHRONIC MEDICINE
Tel: 086 000 2378
Email: medicine@bestmed.co.za
Fax: 012 472 6760

CLAIMS
Tel: 086 000 2378
Email: service@bestmed.co.za (queries)
claims@bestmed.co.za (claim submissions)

MATERNITY CARE
Tel: 012 472 6797
Email: maternity@bestmed.co.za

WALK-IN FACILITY
Block A, Glenfield Office Park,
361 Oberon Avenue, Faerie Glen,
Pretoria, 0081, South Africa

POSTAL ADDRESS
PO Box 2297, Arcadia,
Pretoria, 0001, South Africa

NETCARE 911
Tel: 082 911
Email: customer.service@netcare.co.za (queries)

INTERNATIONAL MEDICAL TRAVEL INSURANCE (EUROP ASSISTANCE)
Tel: 0861 838 333
Claims and emergencies: assist@europassistance.co.za
Travel registrations: bestmed-assist@linkham.com

PMB
Tel: 086 000 2378
Email: pmb@bestmed.co.za

BESTMED HOTLINE, OPERATED BY KPMG
Should you be aware of any fraudulent, corrupt or unethical practices involving Bestmed, members, service providers or employees, please report this anonymously to KPMG.

Hotline:	080 111 0210 toll-free from any Telkom line
Hotfax:	080 020 0796
Hotmail:	fraud@kpmg.co.za
Postal:	KPMG Hotpost, at BNT 371, PO Box 14671, Sinoville, 0129, South Africa

For a more detailed overview of your benefit option and to receive a membership guide please contact service@bestmed.co.za

Bestmed Medical Scheme is a registered medical scheme (Reg. no. 1252) and an Authorised Financial Services Provider (FSP no. 44058). ©Bestmed Medical Scheme. Bestmed Comparative Guide 2025 Brochure A4. This brochure was updated in September 2024. For the most recent version please visit our website at www.bestmed.co.za

Documents are printed on paper procured from sustainable sources.

bestMed

personally yours